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INTRODUCTION

In accordance with the City Auditor's 1994-95 Audit Workplan, we have audited the City of San Jose Employees' Health Plan. We conducted this audit in accordance with generally accepted government auditing standards and limited our work to those areas specified in the Scope and Methodology section of this report.

The City Auditor's Office thanks those individuals in the Human Resources Department who gave their time, information, insight, and cooperation for this audit. Specifically, we thank the Senior Administrative Officer of the Human Resources Department--Benefits Program and his staff for their outstanding responsiveness to our many requests for information.

SCOPE AND METHODOLOGY

Our audit objectives were to:

- Determine opportunities for cost savings;
- Evaluate the effectiveness of the city of San Jose's (City) preferred provider organization;
- Determine whether the third-party administrator is processing claims in accordance with plan provisions and related documents;
- Determine whether claims are paid in the proper amount;
- Determine that documentation was on file for claims paid and such documents submitted were adequately completed with all data necessary to process the claim;
- Evaluate the effectiveness of the computer controls for claims processing and payment;
- Determine whether the turnaround time for processing claims was within acceptable industry standards; and
- Determine whether proper safeguards exist to prevent the City from being charged for expenses of ineligible persons.

We performed only limited testing to determine the accuracy and reliability of the various computer reports used. Such testing included observation or a walk-through of the claims processing, a review of the system documentation, and a statistical sample of the claims processed. We analyzed the processed claims data for a 28-month period. We did not review the general controls for the computer systems used for claims processing.

In reviewing the timeliness and validity of payments, we selected the month of April 1994 for our statistical sample of the claims processed. During April

1994, Foundation Health Preferred Administrators (FHPA) paid 4,946 City of San Jose Employees' Health Plan (CSJEHP) claims totaling $1,114,601. We stratified these claims into the following categories:

1. Claims of $1,000 or greater
2. Claims of $200 or greater but less than $1,000
3. Claims less than $200

Category 1 claims totaled $618,322 and comprised 55.5 percent of total claims payment amounts in April 1994; category 2 claims totaled $250,495 and comprised 22.5 percent of total claims payment amounts in April 1994. We reviewed all 171 claims in category 1, a random sample of 71 of the claims in category 2, and 319 of the claims in category 3. The results of our tests are discussed on page 27 of this report.

The Bank of America keeps the cancelled checks for the CSJEHP claims paid. We did not review the cancelled checks for the claims in our audit samples.

BACKGROUND

The Cost Of Health Care

The U.S. Department of Commerce estimates that health care spending accounted for more than 14 percent of the nation's gross national product in 1992, up from 13.2 percent in the previous year dollar terms. The nation's 1992 health care bill was $838.5 billion and was expected to reach $939.9 billion in 1993.

The city of San Jose's (City) health care expenditures for 1994-95 are expected to be $27.4 million, or about 6 percent, of the proposed General Fund's $489.6 million operating budget. The City has only four departments (Fire, Police, Streets and Parks, and Environmental Services) with budgets that exceed the City's proposed expenditure for health care in 1994-95. Like other employers in Santa Clara County and throughout the country, the City is faced with skyrocketing health care costs.

The City's Goals In Providing Health Care Coverage

The City's overall goal in providing health care coverage is to ensure that employees, retirees, and their families have access to quality medical care and are protected from unexpected or unaffordable medical expenses.

The City's health care goals are to

- Provide adequate health care coverage for City employees and their families;
- Provide a reasonable number of plan choices to cover an array of medical and health care services; and
- Contain costs.

These three goals are not totally compatible with each other. For example, cost containment usually means limiting choices and flexibility. The City, however, has made efforts to balance these goals.

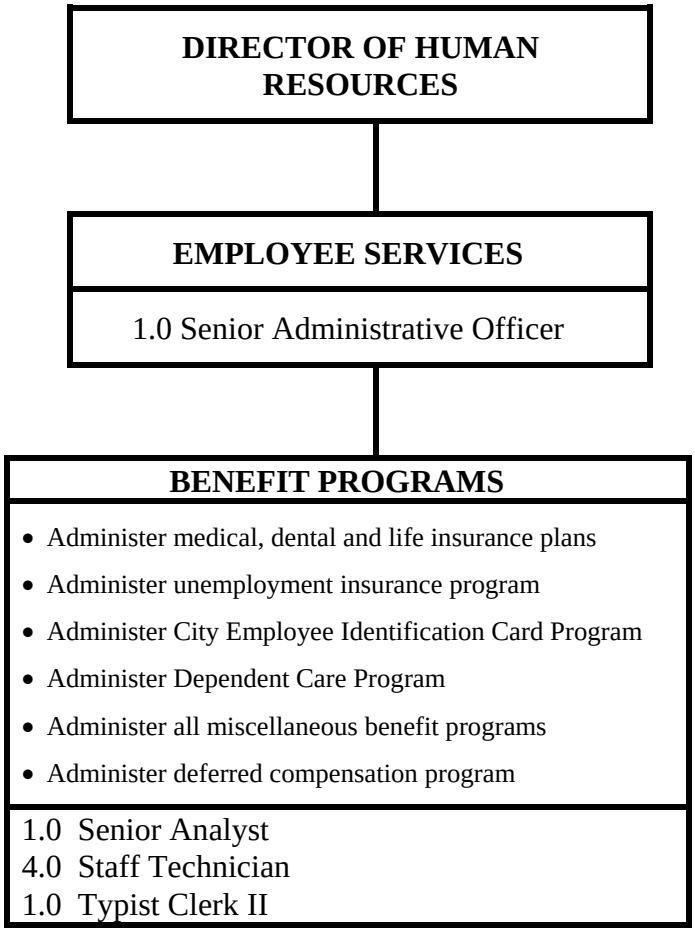
The City's Employee Services Division

The Employee Services Division of the Human Resources Department (HRD) is responsible for administering the City's benefit programs. Chart I shows the organization of the Employee Services Division of the HRD.

The Division's specific responsibilities include overseeing the City's medical, dental, and life insurance plans, unemployment insurance program, and other miscellaneous benefit programs.

CHART I

ORGANIZATION CHART
FOR THE EMPLOYEE SERVICES DIVISION
OF THE HUMAN RESOURCES DEPARTMENT



Funding For Employee Benefits

Employee benefit funds pay for the City's health care expenditures. These funds are the Dental Insurance, Life Insurance, Unemployment Insurance, Employee Benefit, and City of San Jose Employees' Health Plan (CSJEHP) funds. These funds are internal service funds which are used to (1) receive transfers from other City funds, (2) make payments on health care expenditures, and (3) account

for the financing of HRD services to other City departments and offices on a cost-reimbursement basis.

The total health insurance premium for each specific health care plan type is the same for all City employees. The City contributes a certain percentage toward the premium for the employee's health care plan. The percentage the City and the employee pay is determined by each employee representation unit's memorandum of agreement (MOA). For active employees, the City pays 90 percent of the cost of the lowest cost plan for health care coverage. The employee pays 10 percent of the cost of the lowest cost plan (up to a maximum of $25 per month) plus any additional cost for a plan which is not the lowest cost plan. Kaiser Permanente is currently the lowest cost plan.

The premium rates for retirees are the same as for active employees for all three of the City's health care plans. After retirees become eligible for Medicare at age 65, they pay reduced rates with Medicare paying as primary insurer for actual medical costs.

Major Accomplishments Relating
To The City Of San Jose Employees' Health Plan (CSJEHP)

In Appendix B, the HRD informed the City Auditor's Office of its major accomplishments relating to the CSJEHP. According to the HRD, the City has made a number of changes to the CSJEHP in its effort to contain costs. These changes included:

- The establishment of a self-insured plan initially administered by Blue Cross;
- The creation of a separate fund to better track the deposit of premiums and payment of claims/administrative costs;

- Movement from full cost coverage for the lowest cost plan toward a 90/10 cost sharing between the City and enrolled employees;
- Restructuring of the self-insured plan to move away from unrestricted care toward managed care;
- Termination of the relationship with Blue Cross and the selection of Foundation Health Preferred Administrators as the third-party administrator;
- An administrative cost formula based on the number of enrolled employees rather than a percentage of claims costs;
- The incentive of 100 percent payment for services from physicians and hospitals which have agreed to charge reduced rates (through a preferred provider network); and
- The implementation of an optional on-line claims payment system for prescriptions to reduce administrative costs.

In Appendix C, we provide a glossary to define a number of terms relating to health care programs.

FINDING I

THE CITY OF SAN JOSE CAN IMPROVE ITS HEALTH CARE PLAN, REDUCE ITS EMPLOYEES' AND RETIREES' MEDICAL COSTS BY MORE THAN $1 MILLION A YEAR, AND POTENTIALLY RECOVER AN ADDITIONAL $905,000 IN PRIOR YEARS' OVERPAYMENTS

The city of San Jose (City) offers its employees three health care plans of which one is the City of San Jose Employees' Health Plan (CSJEHP). The City contracts with PPO Alliance to administer a series of contractual arrangements with a network of physicians, hospitals, and other medical service providers. The medical service providers with which PPO Alliance contracts are the City's preferred provider organization (PPO). As such, it is in the best interest of the City and its employees that PPO Alliance contract with as many medical service providers as possible and that it negotiate the best possible price for specific medical procedures. In addition, the City contracts with a third-party administrator--Foundation Health Preferred Administrators (FHPA)--to pay and administer medical claims that medical service providers submit for payment for services to those employees in the CSJEHP. As such, it is in the best interest of the City and its employees that the FHPA pay claims in a timely manner and take advantage of all negotiated or available medical service discounts.

Our review of the City's contractual arrangement with PPO Alliance and FHPA and their performance under the City's contract revealed the following:

- At the recommendation of the Benefits Review Forum, the City awarded a contract to PPO Alliance without going through a competitive bidding process and documented evidence does not support the City's decision to award a contract to FHPA;
- FHPA was unable to provide us with documentation for 33 of the 242 claims selected for our review;

- FHPA has not paid medical service claims in a timely manner;
- FHPA has not taken advantage of negotiated or available medical service discounts. As a result, the City's employees and retirees paid $890,000 unnecessarily over the last four years; and
- FHPA paid about $15,000 for ineligible claims during the last four years.

The Santa Clara County PPO option for its employees is the Preferred 100 Plan. Comparing the County's Preferred 100 Plan to the CSJEHP revealed the following:

- PPO Alliance has not provided the City or its employees with a number of medical service providers in its PPO comparable to the County's and
- PPO Alliance has not negotiated discount rates with medical service providers in its PPO comparable to the County's.

Our review also revealed that the City has an opportunity to consolidate with Santa Clara County for a PPO and that by so doing the City will be able to

- Reduce premium costs for both its employees and retirees;
- Obtain better price discounts for medical services;
- Obtain fast-payment discounts;
- Implement additional concurrent utilization reviews of medical service bills; and
- Increase employee use of the PPO.

By forming a medical services purchasing coalition with Santa Clara County, we estimate that the City will save its employees and retirees more than $1 million a year in medical service costs and health insurance premiums. In addition, the City should pursue reimbursement of $905,000 in prior years' overpayments.

CITY OF SAN JOSE HEALTH CARE PLANS

The City has three health care plans that are different by design to provide choices for covered employees. Employees may select the plan which fits their own needs and preferences and may change annually during an open enrollment period if they wish.

The three health care plans the City offers to its employees are of two different kinds of health insurance programs: "wellness" and "illness." The "wellness programs" are the Kaiser Permanente and the Lifeguard programs. Both Kaiser Permanente and Lifeguard are health maintenance organizations (HMO).

Wellness Program

Wellness programs are designed to keep the employee well. They provide regular checkups and immunizations as well as all other medically necessary care and services. There is no paperwork to fill out when the employee goes to the doctor or the hospital. The employee may choose either the Kaiser Permanente or the Lifeguard wellness program. Kaiser and Lifeguard are limited-choice plans which the plan providers administer.

The essential elements of the Kaiser and Lifeguard plan options are summarized in Chart II.

CHART II

ESSENTIAL ELEMENTS OF THE KAISER AND LIFEGUARD PLAN OPTIONS

Kaiser Permanente	Lifeguard
Kaiser Permanente offers a clinic-type program. Services are provided at Kaiser Foundation hospitals and medical offices. The City's Kaiser plan covers virtually all recognized medical services and specialty areas, but services must be obtained through a Kaiser facility. The employee may choose a personal doctor from the staff at these facilities. The City does not participate in Kaiser's durable medical equipment coverage. There is no charge for visits to the doctor or for stays in the hospital. Kaiser Permanente is a closed-panel HMO.	Lifeguard is an open-panel HMO. Lifeguard contracts with physicians and other providers who are practicing in the general community and who maintain a non-HMO practice concurrent with their participation in the HMO. Lifeguard provides preventive medicine as well as standard benefits at standard rates with specific contract doctors and hospitals. Treatment by a specialist physician must be at the referral of a primary care physician. Lifeguard has contracts with more than 3,600 private doctors and 50 hospitals in the Bay Area. Employees may select their own primary doctor from the 3,600 private doctors. Lifeguard has 596 private physicians and 8 contracting hospitals in Santa Clara County. Employees make a small copayment each time they visit a doctor. The City does not participate in Lifeguard's prescription drug program.

Illness Program

The City also offers its employees an illness program which is an insurance program that pays for an employee's medical costs which are the result of an illness or injury. Unlike the wellness programs, the illness program allows the employee to use any doctor or hospital he or she chooses.

The City joined the Blue Cross indemnity health care plan in 1969. However, in 1989 Blue Cross notified the City that unless the City accepted substantial changes to the plan, Blue Cross no longer wished to have the City as a client. The City found the proposed changes to be unacceptable and terminated its contract with Blue Cross on July 31, 1990. On August 1, 1990, the City established the CSJEHP to replace the full-choice Blue Cross plan.

The City and all recognized employee organizations formally agreed on the plan design for the CSJEHP. The plan design included the following provisions:

- The annual deductible would remain at $50 per member, the same as it had been under Blue Cross, with a three-member cap of $150 per enrolled family;
- An annual out-of-pocket maximum for covered hospital expenses in a non-PPO hospital was established at $1,000 per member. Employee organizations reluctantly agreed to this annual maximum per member to encourage participants to use PPO hospitals which guaranteed discounted rates; and
- For the first year (1990), the annual maximum copayment for non-hospital services from non-PPO providers remained at $400 per member. This was the same as the Blue Cross plan for non-Blue Cross doctors/providers. Employee organizations agreed that this maximum would be raised to $500 per member after 1990 to recognize inflation.

HMO vs. Self-Insured Health Care Plan

The CSJEHP is a self-insured health care plan. The plan provides benefits for enrollees and their eligible dependents when medically necessary. The plan covers those illnesses and medical conditions identified in the CSJEHP document. The plan generally covers only medically necessary visits and procedures but not preventive medicine or procedures.

Premiums for HMOs are fixed for the contract term; therefore, the financial risk of the cost of care during the contract term (in excess of the premiums charged) is transferred to the HMO. Consequently, an HMO has an inherent financial incentive to control utilization during the contract term, or else suffer the financial loss. While the CSJEHP allows full choice of physicians and hospitals, it also has financial incentives to encourage employees to use the services of a PPO.

A PPO is an administrative organization that maintains a series of contractual relationships with a network of providers. The PPO contracts with employers, insurance companies, unions, or third-party administrators (TPA) to provide services at reduced rates to those employees that use the PPO. There are many different PPO arrangements, but most have the following features:

- A panel of participating medical service providers. A limited number of medical service providers participate in the PPO;
- A negotiated fee schedule. A lower-than-standard or discounted charge will be made for all professional services;
- Utilization control guarantees. All providers agree to operate within the framework of the plan's cost controls, such as pre-certification on hospital admissions;
- Incentives for members to select the participating providers. Patients retain the right to use other than the participating providers, but often copayments are required for medical services from other than participating providers; and
- Reimbursement mechanisms. In exchange for participation in the PPO, the provider is guaranteed prompt payment.

Members in the CSJEHP have the option to use the services of those doctors and hospitals that are in the PPO. Generally, when a PPO provider provides medical services to a covered employee, the plan pays 100 percent of the cost. When a non-PPO provider provides services to a covered employee, the plan pays 80 percent of the usual, customary, and reasonable (UCR) fees up to the plan's maximum "out-of-pocket" limits. Plan participants are responsible for those amounts in excess of the UCR fees. Included in the plan are provisions for those claimants who live or work more than 50 miles from a PPO provider and for emergency services.

The City pays Kaiser and Lifeguard on a capitation basis. Under this arrangement, monthly premiums are a fixed amount per employee regardless of the type or extent of medical services provided. Conversely, the CSJEHP self-insured program pays providers on a claims basis. Both the City and participating employees pay shares of claims costs as they are incurred per plan specifications.

An employee that chooses to use the CSJEHP has an additional choice of whether to receive care from a PPO provider or from a non-PPO provider.

The Council on Education in Management in its publication, Controlling Employee Benefits, says a PPO has these principal risks:

1. Unlike an HMO, the PPO assumes no risk regarding the cost of medical services. Medical service providers are paid on a fee-for-service basis at an agreed discount. As a result, PPO providers are paid regardless of the cost of care or utilization rates.

2. The non-PPO charge to the employee may not be sufficiently large to direct members to PPO providers.

City Health Care Plan Enrollment Statistics

The active and retired employees enrolled in the City's health care plans as of September 1994 are shown in Table I.

TABLE I

CITY OF SAN JOSE
HEALTH CARE PLAN ENROLLMENTS AS OF SEPTEMBER 1994

	Kaiser	Lifeguard	CSJEHP	Total
Single Coverage				
Active*	798	195	452	1,445
Retired	240	52	417	709
Subtotal	1,038	249	869	2,154
Family Coverage				
Active	2,100	690	862	3,652
Retired	497	30	655	1,182
Subtotal	2,597	720	1,517	4,834
Totals	3,635	967	2,386	6,988
Percentage of Total	52	14	34	100
Comparison of Enrollment--Active vs. Retired				
Active*	2,898	885	1,314	5,097
Retired	737	82	1,072	1,891
Total	3,635	967	2,386	6,988

Total Health Care Plan Enrollments		
	Enrollments	Percentage Of Enrollment
Active	5,097	73
Retired	1,891	27
Total	6,988	100
Single	2,154	31
Family	4,834	69
Total	6,988	100

* Active enrollment amounts exclude COBRA employees as well as employees on leaves of absence.

Contract With PPO Alliance

The City has a contract with PPO Alliance. This organization does the following for the CSJEHP:

- Solicits PPO providers;
- Negotiates fees for services;[1] and
- Ensures that medical service providers are fully qualified and appropriately licensed.

PPO Alliance is a statewide PPO established in late 1983 by two of the largest multi-hospital systems in the western United States: UniHealth America and Adventist Health System/West. The company began marketing its services in spring 1984. During the next two years, another 57 facilities joined the PPO. Between 1991 and 1992, PPO Alliance added an additional 79 facilities, focusing on network expansion in the northern portion of California. As hospitals were added, individual physicians, medical groups, and independent practice associations (IPA) affiliated with PPO hospitals were recruited for membership in the PPO. Today, the statewide PPO consists of 240 facilities and nearly 19,300 practitioners. The corporate office for PPO Alliance is in Woodland Hills, California.

PPO Alliance recruits providers following a sequential process that begins with the incorporation of hospitals into the PPO. The following guidelines determine eligibility for hospital PPO membership:

- The hospital must be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO);

[1] See Appendix D for potential hospital and physician savings as described in the PPO Alliance Plus Directory for Northern California 1993-94.

- There must be a minimum of 85 percent board-certified or board-eligible physicians on active staff;
- The hospital must be a market leader and must possess community prestige and institutional reputation;
- The hospital must offer a full range of services;
- The hospital's location must be in proximity to other participating hospitals;
- The hospital must have a demonstrated ability to achieve reasonable participation of medical staff; and
- The hospital must show a commitment to managed care and successful participation in risk contracting.

Once the hospitals are enrolled, PPO Alliance recruits its physician staff members. PPO Alliance's preferred method is to develop relationships with hospital-sponsored, or designated, IPAs or medical groups. If none are available, PPO Alliance solicits individual staff physicians with active privileges. In addition, PPO Alliance recruits physicians where specific specialty and geographic coverage is needed.

To ensure that the physicians joining the PPO Alliance network practice at the highest standards, PPO Alliance has developed a two-pronged approach to verifying physician credentials. First, PPO Alliance relies on the contracting hospitals, IPAs, and organized medical groups to perform a large part of the quality assurance screening of providers. As a result, PPO Alliance has set two major requirements for membership. Each member must have:

- Active admitting privileges at a participating hospital and

- Professional liability coverage in amounts consistent with community standards (usually amounts in excess of $500,000 per incident and $1,000,000 in the aggregate).

Inherent in these requirements are additional criteria or standards that must be met. For example, since the JCAHO accredits PPO Alliance acute care facilities, each provider must meet and maintain certain JCAHO-set minimum medical staff criteria. Specific requirements include appropriate licensure, relevant training and/or expertise, and current competence in the physician's field of practice. When reviewing an applicant, the hospital may verify that the applicant has adequate professional liability insurance and determine if the applicant (1) is involved in any professional liability action, (2) has had challenges made to his or her license or registration, and (3) has previously lost medical staff membership.

All PPO Alliance hospitals are committed to providing high quality services. The majority of PPO Alliance physicians are board-certified or board-eligible in their respective specialties and must have staff privileges at one or more of the medical facilities.

Contract With Foundation Health Preferred Administrators (FHPA)

FHPA is the City's third-party administrator (TPA) for the City's self-insured health care plan (CSJEHP). FHPA, a subsidiary of Foundation Health Corporation, is a full-service TPA for claims and referral management. The subsidiary covers approximately 150,000 participants. Clients include physician groups and employers with self-insured health care programs. FHPA originated as Preferred Administrators Insurance Services located in Palo Alto, California, and became operational on January 1, 1986.

FHPA's parent company, Foundation Health Corporation, is one of the largest statewide HMOs in California. Foundation Health Corporation operates several businesses, with most stemming from its core HMO. The company initially concentrated operations in the Central Valley of California, notably the Sacramento area, and maintained this core presence after plans outside the state were divested. The company gradually expanded into the San Francisco Bay Area and became one of the largest HMOs in northern California. Foundation Health Corporation provides managed health care services to approximately 3.4 million eligible individuals, primarily in California, through its HMO, government contracting, and specialty managed care subsidiaries. In July 1993, the Department of Defense notified Foundation Health Corporation that it was not selected to continue as the contractor for the CHAMPUS Reform Initiative (CRI) in California and Hawaii, a program which provided over 40 percent of the company's revenues in 1993. Foundation Health Corporation was the prime contractor pursuant to the CRI under one of the largest government health care contracts in the United States, covering about 860,000 eligible military-related beneficiaries in California and Hawaii. The Department of Defense instead awarded its $3.5 billion Pentagon contract to provide medical care for these military retirees and their dependents to the San Diego-based unit of Aetna Life & Casualty Company.

The scope of FHPA's services for the CSJEHP is claims administration, payment of claims, utilization review, and large case management.[2] Benefits are provided for enrollees and their eligible dependents when medically necessary. Coverage includes illness and certain medical conditions identified in the CSJEHP

[2] For detailed description of scope of services in the contract between the City and FHPA, see Appendix E.

document. Only medically necessary visits and procedures are covered; preventive medicine is generally not provided.

The City compensates FHPA at a fixed amount per enrollee per month for claims administration and a fixed amount per enrollee per month for utilization review services. In addition, the City pays FHPA at an hourly rate for large case management services performed in accordance with the terms and conditions of the agreement.

FHPA paid the following number of CSJEHP claims for 1991, 1992, and 1993:

Calendar Year	Number of Claims
1991	42,722
1992	56,320
1993	63,470

The CSJEHP payment of claims amounts were as follows for the last three fiscal years:

Fiscal Year Ended	Payment Of Claims Amount
June 30, 1992	$10,701,001
June 30, 1993	$9,527,622
June 30, 1994	$9,614,445

Appendix F shows FHPA's claims processing flow chart.

At The Recommendation Of The Benefits Review Forum, The City Awarded A Contract To PPO Alliance Without Going Through A Competitive Bidding Process, And Documented Evidence Does Not Support The City's Decision To Award A Contract To FHPA

The City did not select PPO Alliance through a request for proposal (RFP) process when it decided to no longer have Blue Cross process claims. According to the Human Resources Department (HRD) personnel, FHPA gave the City three PPO options from which to choose. Of the three options, the Benefits Review Forum recommended PPO Alliance because the City was looking for both a PPO and a TPA and FHPA already had the PPO Alliance Plus network on its computer system.

We also noted the following anomalies in the City files for the selection of the TPA and the PPO in 1990:

1. There were seven companies that submitted proposals. Their quotations for the costs of administration varied from a low of $9.40 per employee per month to a high of $15.18 per employee per month. Thus, there was a variance of $5.78 or 61 percent. We saw no analysis of this variance, and the TPA the City did select had a quoted price of $9.84 per employee, which was 4.7 percent higher than the lowest quoted price. In addition, the City did not require the companies to itemize the components of the administration costs, such as, claims administration, eligibility, subrogation, and basic management reports. In our opinion, the City's specifications were too general. This contributed to the unexplained wide variation in the price quotations and caused the resultant contractual provisions that were based on the RFP to lack sufficient specificity.

2. The TPA selected had the least experience.

3. The TPA selected had the smallest number of clients in California.

4. The City did not request how often the UCR fees would be updated.

5. When proposals were requested, the City's health care plan had an enrollment of 1,650 active employees (65 percent) and 870 retirees (35 percent). The City placed more emphasis on a quality statewide PPO which would tend to benefit retirees, rather than an effective PPO in the immediate area which would tend to benefit active employees.

6. Of the seven companies submitting proposals, two had more than three times the number of physicians in Santa Clara County in their PPOs than the company the City selected.

7. Of the seven companies submitting proposals, four had more hospitals in Santa Clara County in their PPOs than the company the City selected.

8. Of the seven companies submitting proposals, four had a larger number of physicians statewide in their PPOs than the company selected.

9. The City did on-site visits for only two of the seven companies submitting proposals to evaluate the computer systems for claims processing.

On February 20, 1990, the Director of HRD sent a memorandum to the City Manager which provided an update on the process of selecting a TPA to replace Blue Cross. The role of the TPA was to pay claims, monitor eligibility, coordinate hospital review services and PPO provider discounts, and provide a variety of utilization reports. The HRD was coordinating the selection of the TPA in conjunction with the Benefits Review Forum. In her memorandum, the Director of HRD said the selection criteria included experience, organizational structure, computerization, reporting capability, references, review services organization, and the extensiveness of the PPOs.

Request For Proposal Process

The ideal time to check to make sure that key players and decision-makers understand the business ramifications of selecting a medical vendor is during the process of preparing an RFP.

Linda F. Jones and Jorge A. Font, in the article entitled "Meeting Employer Needs In The Managed Care Request For Proposal Process," Health Care Financing, Winter 1992, made the following comments:

> *Managed care has become an important vehicle for employers in implementing cost containment efforts. . . . As managed care has gained acceptance, there has been a surge of competition among managed care vendors . . . .*
>
> *Over the past few years, employers have also become more sophisticated in their understanding of managed care and are rightfully demanding services that ensure cost savings, quality standards of care, and performance guarantees that satisfy employee needs and organizational goals. It is no wonder that vendor relationships based on historical agreements are being challenged. Increased competition and demands on accountability have made the request for proposal (RFP) process a more critical step in ensuring that the right vendor is selected to deliver quality, affordable services that meet the organization's expectations.* [Emphasis added]
>
> *Implementing a managed care RFP process is one that should not be performed hastily. Employers should initiate the process by defining basic service requirements demanded from a managed care program. Definition of these specifications, written into the RFP, serves an essential role in facilitating the vendor evaluation and selection process. Ideal candidates are those who meet or exceed minimum capabilities, as well as offer creative approaches in customizing their services to meet organizational needs.*
>
> *The RFP process is systematic by design. The following discussion outlines the sequence of steps typically followed to facilitate vendor evaluation and selection to ensure that the best vendor is* [selected] *to address an organization's needs.*
>
> ***Step 1. Development of a managed care strategy***
> *The building block of the RFP process is the development of the organization's managed care strategy, both short-term and long-term. This strategy statement is instrumental in assuring that the development of a managed care*

system is consistent with the company's overall health care philosophy, strategy, and objectives on a year-by-year basis.

Step 2. Assess the existing benefit plan

Step 3. Determine the timing for implementation of managed care programs
Implementation of different managed care programs typically does not occur simultaneously, but is phased-in to allow timely, successful integration into the existing health benefits structure.

Step 4. Prepare an RFP questionnaire to collect relevant data

Step 5. Analyze vendor RFP responses and quantify findings

Step 6. Summarize findings and identify finalists

Step 7. Conduct interviews with finalists

Step 8. Check references

Step 9. Formal presentation of findings and recommendations

Step 10. Workplan for implementation

With rampant changes occurring in the health care environment and the overriding concern with rising costs, employers must be deliberate in their design of managed care programs. A well-designed RFP questionnaire and systematic process can ensure that the employer has achieved the vendor selection that optimally meets organizational goals, objectives, and employee needs.

The above process is designed to permit the vendors to best address the soliciting entity's needs. Some authorities say that if an organization needs help in the RFP process, it should retain a consultant. Discussion with HRD personnel indicated that in 1989 the City had not formulated a long-term managed care strategy before implementing the RFP process to select a TPA.

Test Of Medical Claims

In reviewing the timeliness and validity of payments, we selected the month of April 1994 for our statistical sample of claims processed. In April, FHPA paid 4,946 CSJEHP claims totaling $1,114,601. We stratified these claims into the following categories:

1. ***Claims of $1,000 or greater***. During April 1994, FHPA paid 171 CSJEHP claims of $1,000 or greater. Although these 171 claims were only 3.5 percent of the total number of claims, the payments for these claims were $618,322, or 55.5 percent of the total claims payment amounts. We included in our test all 171 claims of $1,000 or greater. FHPA was unable to provide to us the documentation for 23 of the 171 claims (see page 27). However, we were able to review for timeliness all 171 payments in this category.

2. ***Claims of $200 or greater but less than $1,000***. During April 1994, FHPA paid 634 CSJEHP claims of $200 or greater but less than $1,000. These 634 claims were only 12.8 percent of the total number of claims but represented $250,495, or 22.5 percent of the total claims payment amounts. For our audit sample, we randomly selected 71 claims from this category. FHPA was unable to provide to us the documentation for 10 of the 71 claims selected (see page 27). However, we were able to review for timeliness all 71 payments in this category.

3. ***Claims less than $200***. During April 1994, FHPA paid 4,141 CSJEHP claims less than $200. We performed limited tests on these claims because although they represent a large percentage (83.7 percent) of the total number of claims paid for the month, they represent only a small share of total claims payment amounts (22.1 percent). Our testing of claims less than $200 was limited to reviewing 319 claims for timeliness of processing.

FHPA Was Unable To Provide Us With Documentation
For 33 Of The 242 Claims Selected For Our Review

As mentioned above, we selected for our review all 171 claims in category 1. Additionally, we selected a random sample of 71 claims in category 2. We initially requested the documentation for these claims on June 5, 1994. FHPA was unable to provide us documentation for 23 of the 171 category 1 claims and 10 of the 71 category 2 claims. Despite repeated requests in July, August, and September 1994, including requests made directly to the FHPA vice president of Operations, FHPA still failed to provide us with the requested documentation. Consequently, we were unable to determine the validity of 23 category 1 claims (which totaled $56,300) and 10 category 2 claims (which totaled $5,048).

Except for the 33 claims for which documentation was not made available to us, we were satisfied that the categories 1 and 2 claims we selected for review were valid medical payments in accordance with the CSJEHP agreement. Because of the relatively small dollar amount represented by category 3 claims, we did not review these claims for validity.

In our opinion, the HRD should set a deadline for FHPA to provide the documentation that we requested during our audit. If FHPA fails to provide the documentation, the HRD should disallow the amounts paid for undocumented medical claims.

FHPA Has Not Paid Medical Claims In A Timely Manner

We summarized the claims turnaround times for the 242 claims in our sample. FHPA calculates claims turnaround time as the number of days required to process a claim after FHPA receives it. Our sample indicated FHPA was not meeting its own claims turnaround target of processing 80 percent of the claims

within 10 business days and 97 percent within 28 business days.[3] Our tests showed that FHPA processed only 34.57 percent of the claims within 10.7 business days and only 88.89 percent of the claims within 28 business days. Table II summarizes our results:

TABLE II

SUMMARY OF CLAIMS TURNAROUND TIMES
FOR CATEGORIES 1 AND 2 CLAIMS

Business Days	Sample Claims Processed	Sample Claims Paid	Percentage Processed	Percentage Paid	FHPA's Claims Processing Targets
7.14	17	4	7.00	1.65	
10					80%
10.71	84	10	34.57	4.13	
14.28	179	38	73.66	15.70	
17.85	200	90	82.30	37.19	
21.42	209	130	86.01	53.72	
25	211	148	86.83	61.15	
28	216	156	88.89	64.47	97%
32.14	222	166	91.36	68.60	
35.71	230	187	94.65	77.27	
Over 35.71	242	242	100.00	100.00	100%

Based on the results of the above sample, we conducted additional tests to verify the claims turnaround time for the 4,141 claims less than $200 that the TPA paid in April 1994. We randomly sampled 319 of these 4,141 claims to assess the claims turnaround time. Our tests showed that FHPA was not meeting its own

[3] Generally, 5 business days equal 7 calendar days; thus, for example, 10 business days are equal to 14 calendar days.

internal standard of processing 80 percent of the claims within 10 business days. Specifically, FHPA had processed only 39.18 percent[4] of the claims after 10.71 business days.

Table III shows the results of our tests.

TABLE III

SUMMARY OF CLAIMS TURNAROUND TIMES
FOR CATEGORY 3 CLAIMS

Business Days	Sample Claims Processed	Sample Claims Paid	Percentage Processed	Percentage Paid	FHPA's Claims Processing Target
7.14	12	10	3.76	3.13	
10					80%
10.71	125	21	39.18	6.58	
14.28	267	101	83.70	31.66	
17.85	291	209	91.22	65.52	
21.42	296	261	92.79	81.82	
25	302	271	94.67	84.95	
28	308	274	96.55	85.89	97%
32.14	309	280	96.87	87.77	
35.71	313	284	98.12	89.03	
Over 35.71	319	319	100.00	100.00	100%

[4] Our total audit sample size of 561 claims for our review of timeliness of claims payment was initially designed to produce a confidence level of 90 percent with a precision of plus or minus 2 percent, based on an expected error rate not exceeding 5 percent. However, because the sample disclosed an error rate of 60 percent instead of 5 percent or less, the revised precision associated with our sample is estimated at plus or minus 7 percent.

In addition, we compared FHPA's internal standards of performance for claims processing to industry standards and another TPA's standards for claims processing. The results of our comparison are shown below:

FHPA Performance Standard	Industry Performance Standard	Surveyed TPA
80% within 10 business days & 97% within 28 business days	90% within 10 business days	95% within 10.71 business days

Source: Industry performance standard provided by Deloitte & Touche.

As is shown above, FHPA is not processing claims within its own standards and those standards are significantly lower than industry and another TPA's standards.

When FHPA submitted its proposal to the City in 1990, it said its maximum claims paid turnaround objective was 7 to 14 calendar days. Further, FHPA told the City that historically it met or exceeded its 7- to 14-calendar day objectives.

In June 1994, FHPA sent a letter to CSJEHP members which said:

> *Effective June 27, 1994, Foundation Health Preferred Administrators (FHPA) will consolidate their Claims Processing and Utilization Management operations resulting in the relocation of these services from Palo Alto to the Sacramento area. There will be no interruption to FHPA's service resulting from the office relocation. This move is expected to provide overall enhanced service to the plans administered by FHPA.*

According to HRD personnel, FHPA's claims processing turnaround time significantly deteriorated after FHPA relocated to the Sacramento area in June 1994. As was noted above, our testing of FHPA claims processing was for the month of April 1994--two months before FHPA's relocation.

PPO Alliance physician contracts state the following about the payor's (FHPA) responsibility to pay claims on time:

> *Pay Practitioner, to the extent Payor is financially responsible as the primary payor under applicable coordination of benefit rules for Covered Services, within thirty (30) days of receipt of a complete and proper claim for services rendered by PRACTITIONER to a Participant, or within such sooner period as may be required by law; or notify PRACTITIONER within thirty (30) days of receipt of a claim which is not complete or proper, together with a description of the manner in which the claim is deficient. Upon failure by a Payor to make payment or otherwise respond hereunder within sixty (60) days of the Payor's receipt of a claim, PRACTITIONER may bill the Participant for such services at PRACTITIONER'S usual and customary charges for the services; provided, however, that in no event shall PRACTITIONER thereby be deemed to have waived any right to proceed against the Payor for payment for Covered Services; and provided, further, that PRACTITIONER'S rights hereunder are in addition to and not in lieu of any other rights that PRACTITIONER may have at law, including, without limitation, any rights under Section 1371 of the California Health & Safety Code and Sections 10123.13 and 11512.180 of the California Insurance Code.* [Emphasis added]

As noted above, FHPA's failure to make payments or notify practitioners of improper claims within 60 days can result in the City and its employees paying higher (UCR) fees. In June 1994, we reviewed the results of our audit tests with HRD. HRD subsequently included in its contract with the TPA effective June 1994 the following provision:

> *PAYMENT OF CLAIMS*
>
> *CONSULTANT shall take all reasonable steps necessary to process claims and disburse Benefit payments to persons entitled to such payments under the Plan. The CONSULTANT agrees to maintain an inventory of unprocessed claims of no more than 10 calendar days.*

FHPA Has Not Taken Advantage Of Negotiated Or Available Medical Service Discounts, And As A Result Cost The City's Employees And Retirees About $890,000 Over The Last Four Years

The American Medical Association (AMA) has prepared a systematic listing and coding of physician procedures and services. This listing is called the Physicians' Current Procedural Terminology (CPT). Each procedure or service is identified by a five-digit code. Currently, there are approximately 8,650 CPT codes. The use of CPT codes simplifies the reporting of services. This coding and recording system allows for accurate descriptions and identification of physician procedures or services.

PPO Alliance negotiates physician reimbursement rates for various geographical locations for medicine, surgery, radiology, pathology, and anesthesia categories. These negotiated physician reimbursement rates are used to determine the payment to a PPO physician. The payment to a PPO physician is determined by multiplying the appropriate negotiated rate by the California relative value for each CPT code. The Conversion Manual for the California Relative Value Studies (CRVS) says the following:

> *The Relative Value Studies is a reflection of the practice of medicine in California. It is a coded listing of physician services with unit values to indicate the relativity within each individual section of median charges by physicians for these services. Since the unit values reflect medians of charges by California physicians, they do not necessarily reflect the charges of any individual physician nor the pattern of charges in any specific area of California.*

Our review disclosed that FHPA's computer system did not have relative values for a significant number of CPT codes. From November 12, 1992, to June 2, 1994, FHPA's CPT dictionary had 8,219 CPT codes in use. Of these, FHPA's computer system had no relative value for 4,470 (54.39 percent) of the CPT codes.

As of June 3, 1994, FHPA's CPT dictionary had 8,658 CPT codes in use. Of these, FHPA's system had no relative value for 1,473 (17.01 percent) of the CPT codes.[5] For those codes with no relative unit values, the City cannot take advantage of the PPO physician discounts.

Table IV summarizes our count.

TABLE IV

PERCENTAGE CALCULATION OF CPT CODES WITH NO RELATIVE VALUE FROM NOVEMBER 12, 1992, TO JUNE 2, 1994, AND AS OF JUNE 3, 1994

	November 12, 1992, To June 2, 1994	As Of June 3, 1994
Number of pages	329	347
Range of CPT codes	00100-99499	00100-99499
Number of CPT codes	8,219	8,658
Number of CPT codes with no relative value	4,470	1,473
Percentage with no relative value	54.39	17.01

For those PPO medical services and procedures (CPT codes) that had no relative value, FHPA had to pay the claims as billed because it could not discount the claims. This not only resulted in excess claims payments but increased

[5] FHPA Management Information System personnel told us it recently installed a database from Medata. FHPA told us it switched to Medata because it provided more information than the previous database from the Health Insurance Association of America, particularly the availability of data by RBRVS (Revenue Based Relative Value System). Medata is a data analysis firm which collects and tabulates fee information to form a database. The database is based solely upon Medata's own relative value units derived from a study of more than 30 million provider charges. The installation of this database appears to account for the reduction of 2,997 CPT codes having no relative value.

premiums for CSJEHP participants as well. This is due to CSJEHP premiums being determined annually based on the prior year's claims costs. In other words, higher than necessary claims costs in one year result in higher than necessary premiums in the next year.

PPO Alliance only recently purchased a proprietary medical software program called "Gap-Fill" from Medical Data Resources (MDR). This program provides a relative value for each CPT code. This program will fill the relative value coding holes for approximately 94 percent of all current CPT codes. It should be noted that the account executive for MDR told us this program has been on the market for five to six years.

To determine the effect of the missing relative values in FHPA's computer system on the payment of claims for the CSJEHP, we analyzed the CSJEHP claims that FHPA paid to PPO providers for the period of January 1, 1992, through April 30, 1994--a 28-month period. On August 1, 1990, the City entered into a contract with FHPA to process claims, and in June 1994 FHPA updated the relative values in its computer system to allow more discounting. We selected this 28-month period because it was representative of the
August 1, 1990, to June 1994 period in question.

Our analysis showed that FHPA paid as billed, without discount, $2,166,326 for 28,704 procedures. Applying the results of our 28-month analysis to the entire August 1990 to June 1994 period, we estimate FHPA paid $3,558,974 as billed without discount for 47,150 procedures. Given that the overall average percentage discount realized through CSJEHP PPO providers is 25 percent, we estimate the City lost discounts amounting to about $890,000.

In order to corroborate our estimate of $890,000 in lost discounts, we further analyzed the payments to PPO physicians for medical procedures having no relative value from our April 1994 statistical sample of claims.[6] We found 65 procedures in our April 1994 sample that were paid as billed without discount. We estimate that the City would have saved $19,322 had these 65 claims been discounted. Applying our estimated monthly discount lost of $19,322 for the 46-month period from August 1990 to June 1994, we estimated the total to be $888,812 which is almost exactly the same as our other estimate of $890,000. It should be noted that although the actual savings may vary each month, the systemic condition that caused these lost discounts has been pervasive from August 1, 1990, through May 31, 1994.

We contacted two other TPAs to determine what their practices are when they have no relative values for CPT codes. Both TPAs indicated they do not have an inordinate number of CPT codes with no relative values. Both TPA administrators indicated manual intervention, not nondiscretionary computer controls, is necessary to determine the amount to be paid when a CPT code has no relative value. For example, the Santa Clara County authorizes its TPA to pay a percentage of the UCR fees when there is no relative value for a CPT code. As a result, the County still realizes a payment savings even when these CPT codes have no relative value.

PPO Alliance negotiated a similar arrangement with its medical service providers. According to the PPO Alliance's Physician Reimbursement Schedule, the discounts for charges when there was no relative value for a CPT code were 10

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[6] Our sample excluded claims less than $200.

percent from May 1, 1990, through April 30, 1992, and 20 percent from May 1, 1992, and thereafter. However, FHPA did not take the discounts when it reimbursed applicable charges. As a result, we estimate that from August 1, 1990, to August 31, 1994, active and retired City employees lost $582,000 in already-negotiated and available discounts.[7]

Jeffrey Mamorsky says the following in his chapter on "Auditing Claims Administration Performance," Health Care Handbook: "*The accuracy of claim payment affects both the cost of benefit programs and employee satisfaction with the programs either directly or indirectly*." With a self-insured claims payment process, the City is at risk for the TPA paying too much for claims.

In our opinion, FHPA and PPO Alliance have not been effective in ensuring that the CSJEHP is able to take full advantage of the physician discount rates. Consequently, from August 1, 1990, to August 31, 1994, the CSJEHP lost (1) actual discounts of approximately $582,000 based on already-negotiated and available discounts and (2) additional potential discounts of $308,000 that would have been available to CSJEHP had all CPT codes been assigned relative unit values. Thus, we estimate actual and potential lost discounts from August 1, 1990, to August 31, 1994, at $890,000.

[7] See Appendix L.

FHPA Paid About $15,000 On Ineligible Claims During The Last Four Years

The CSJEHP document says the following about conditions of enrollment:

The following persons are eligible for coverage as family Members of the Subscriber:

The Subscriber's Spouse.

Unmarried Children to the 19th birthday.

Unmarried Children from the 19th to the 23rd birthday who qualify as dependents for federal income tax purposes, and are full time students at an accredited college. The claims administrators must receive this information in writing and such eligibility must be confirmed prior to payment of claims each semester.

Unmarried Children enrolled before age 23 who, upon reaching age 23, depend on the Subscriber for support and are unable to work due to mental retardation or physical handicap. A physician must certify this disability in writing. This certification must be received by the claims administrators within 31 days of the Child's 23rd birthday. After the Child's 25th birthday, the claims administrators may request proof of continuing dependency and disability, but not more often than yearly.

Eligible surviving spouse and/or children of deceased Members.

Thus, the CSJEHP is quite specific as to whom the TPA covers.

The CSJEHP has the following relevant cancellation provisions for eligibility:

CANCELLATION OF COVERAGE

CHILD

On the date the Subscriber's coverage is canceled (except when due to the Subscriber's death), or

On the date the child reaches age 19 or is no longer a full time student in an accredited school or no longer qualifies as a dependent for federal income tax purposes or reaches age 23 (unless the child elects Continuation of Coverage)[8]*, or*

On the date of marriage (unless the child elects Continuation of Coverage)

On the date the Plan receives written notice terminating the child's coverage

From FHPA's membership listing as of February 28, 1994, we counted in excess of 150 dependents with a date of birth prior to November 30, 1974. As such, full-time student status would be the only remaining criterion for eligibility. However, the membership listing showed that these individuals did not have student eligibility. We reviewed the history of charges for these dependents and found charges totaling $13,086 for 33 of the more than 150 non-qualifying dependents. Our analysis of FHPA's membership listing as of February 28, 1994, also showed 155 over-aged dependents who would not qualify for coverage regardless of student status. We found ineligible charges totaling $1,708 for 8 of these 155 over-aged dependents. Thus, we identified over 300 ineligible persons on the CSJEHP membership list as of February 28, 1994, of which 41 received CSJEHP medical service benefits totaling about $15,000.

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[8] It should be noted that the Benefits Review Forum, the City's labor-management committee, recently approved that the qualifying age for student dependents be increased to 24 in order to establish uniformity with other benefit plans.

It should be noted that our estimate of ineligible claimant payments was limited to FHPA's membership listing as of February 28, 1994. We made no attempt to quantify total ineligible claimant payments for the period of August 1, 1990, to February 28, 1994.

According to the City's current contractual agreement, the City's obligations for enrollment are as follows:

- City shall control enrollment in CSJEHP and enter enrollment changes, additions, or deletions in the eligibility system using the on-line terminal system provided by FHPA. City shall provide FHPA with prompt notice of new enrollees and enrollees no longer entitled to receive CSJEHP benefits.

To implement this contractual provision, the City has developed written procedures which include the following:

- Maintenance of membership is shared by the Employee Services Division and Retirement Section of HRD and the Payroll Section of the Finance Department. The City has assigned the responsibility for eligibility verification to the Employee Services Division of HRD. The Employee Services Division has the following relevant responsibilities:

  1. Verifying student status and flagging membership eligibility;

  2. Making necessary notes in the file regarding membership; and

  3. Adding new members and deleting members who have transferred to other health care plans after the open enrollment period has ended.

According to the City's current contractual agreement with FHPA, FHPA has the following obligations for payment of claims:

- FHPA shall take all reasonable steps necessary to process claims and disburse medical service payments to persons entitled to such payments

under the CSJEHP. To implement this contractual provision for eligibility, FHPA does the following:

1. Sends monthly membership list to the Employee Services Division;
2. Sends letters to members who have children who are reaching the age of 19 informing them of the requirement to maintain full-time student status or requesting information regarding disability; and
3. Sends letters to members who have children reaching the age of 23 informing them of ineligibility and of COBRA.

The City does not periodically receive an exception report from FHPA for potential ineligible participants.

In April 1988, the American Institute of Certified Public Accountants (AICPA) issued Statement on Auditing Standards 55, Consideration of the Internal Control Structure in a Financial Statement Audit which refers to three elements of an entity's internal control structure: the control environment, the accounting system, and control procedures. Control procedures are those policies and procedures instituted in addition to the control environment and accounting system that management has established to provide reasonable assurance that specific entity objectives will be achieved. Generally, control procedures may be categorized as procedures that pertain to the following:

- Proper authorization of transactions and activities and
- Independent checks on performance.

By not effectively monitoring the eligibility of CSJEHP dependents, $15,000 in medical service claims was paid for non-qualifying dependents. These improper payments not only increase costs to the City but cause additional premium charges for CSJEHP members as well.

In our opinion, the HRD needs to

1. Develop and implement more effective procedures to ensure that the current eligibility files for the CSJEHP are complete and accurate;

2. Develop and implement more effective procedures to monitor the continuing eligibility of the employees and their dependents for the CSJEHP. Such procedures could include requesting that the TPA produce an exception report semi-annually of potential ineligible dependents as a basis for monitoring eligibility; and

3. Consult with the City Attorney regarding possible City recourse to recover the amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994.

In addition, the HRD and the Benefits Review Forum should request funding for a full-time analyst to provide a variety of functions related to the CSJEHP including:

1. Monitoring claims payment for compliance with plan design and contractual discounts;

2. Reviewing claims reports for abnormal patterns of usage;

3. Monitoring and analyzing utilization reports to determine potential benefit changes (i.e., identify seldom used, frequently used, and abused procedures);

4. Preparing monthly reports on all aspects of utilization;

5. Monitoring enrollment of dependents;

6. Coordinating utilization of all available City benefits;

7. Developing training/wellness strategies for recurrent claims problems (i.e., back injuries, alcohol/drug abuse, lung disease, mental health/stress);

8. Providing educational seminars for employees on appropriate uses of doctors/hospitals, inpatient versus outpatient, and uses of PPOs; and

9. Reviewing and solving employee problems with the PPOs and/or TPA.

Comparing Santa Clara County's Preferred 100 Plan To The CSJEHP

PPO Alliance Has Not Provided The City
Or Its Employees With A Number Of Medical Service Providers
In Its PPO Comparable To Santa Clara County's

The number of physicians in the City's PPO has not ranked in the top ten for the last five years when compared to other PPOs in Santa Clara County. The San Jose Business Journal annually produces a report showing the major PPOs in the County. The Business Journal showed that PPO Alliance had the following rankings based on the number of physicians in its PPO:

Year	PPO Alliance Ranking
1989	13th
1990	13th
1991	11th
1992	12th
1993	14th

Note: Appendix G shows these rankings.

PPO Alliance told us it had 1,043 PPO providers in Santa Clara County as of January 7, 1994, of which 949 were physicians. During the second half of 1994, a supplemental PPO provider directory was sent to CSJEHP members. PPO Alliance added more PPO providers to the directory as a result of the inclusion of the Stanford University Clinic in the PPO. However, as noted earlier in this report, the addition of providers to the PPO does not guarantee that the CSJEHP will

receive discounts unless FHPA's computer system has relative values for these physician services.

It is in the City's employees' best interest to have as many physicians in its PPO as possible. The more physicians in the PPO, the greater the chance that employees will use a physician in the PPO and save money. Accordingly, by having only the eleventh to fourteenth largest PPO network of physicians in Santa Clara County, the City's employees have lost opportunities to save money on physician services.

PPO Alliance Has Not Negotiated Discount Rates
With The Medical Service Providers
In Its PPO Comparable To Santa Clara County's

PPO Alliance negotiates physician reimbursement rates for various geographical locations for the following categories: medicine, surgery, radiology, pathology, and anesthesia. These negotiated physician reimbursement rates are used to determine the payment to a PPO physician. The payment to a PPO physician is determined by multiplying the negotiated rate by the relative value for each CPT code. Relative values assign comparative numerical values to medical services and procedures. Although the relative values are generally presented in non-monetary units, they can be translated into fees by applying a dollar conversion factor, such as a physician reimbursement rate.

PPO Alliance has negotiated for the City the following physician reimbursement rates for the San Francisco Bay Area including San Benito County:

Category	Rate
Medicine	$7.24
Surgery	$182.58
Radiology	$14.92
Pathology	$1.71
Anesthesia	$38.39--$42.66

When we compared the CSJEHP PPO physician reimbursement rates to Santa Clara County's PPO physician reimbursement rates, we found that the CSJEHP's rates were higher across the board. Specifically, the CSJEHP's rates were higher as follows:

Category	Percentage CSJEHP PPO Physician Rates Are Higher Than Santa Clara County's
Medicine	3.43
Surgery	6.46
Radiology	9.30
Pathology	4.91
Anesthesia	*

Note: The PPO rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

The physician reimbursement rates are important to the City because they affect the payments made for PPO physician services. CSJEHP costs for PPO physician services for the calendar years ending 1991, 1992, and 1993 were $1,338,720, $1,696,496, and $1,744,740, respectively. The medicine and surgery physician reimbursement rates are particularly significant for the CSJEHP as the

payments for these services were 80 percent, 83 percent, and 84 percent, respectively, of the total PPO physician payments for these three years.

Table V shows the CSJEHP payments to PPO physicians for the calendar years ending 1991, 1992, and 1993.

TABLE V

CSJEHP PAYMENTS TO PPO PHYSICIANS
DURING 1991, 1992, AND 1993

Physician Services (CPT)	PPO Paid	Percentage
Medicine	$2,068,971	43
Surgery	1,881,293	39
Radiology	374,440	8
Pathology/Lab	236,709	5
Anesthesia	122,729	3
Uncoded	95,807	2
TOTAL	$4,779,949	100

Santa Clara County's PPO Option--The Preferred 100 Plan

Santa Clara County also has a self-insured health care plan--the Preferred 100 Plan. The Business Journal excluded Santa Clara County's PPO from its analysis. The County negotiates directly with physicians, hospitals, and other providers. As of January 21, 1994, Santa Clara County's Preferred 100 Plan had 3,198 providers in Santa Clara County of which 2,263 were physicians. As was noted earlier, PPO Alliance had only 1,043 Santa Clara County PPO providers as of January 1994 of which 949 were PPO physicians. After January 21, 1994, Santa Clara County's Preferred 100 Plan added more providers to its PPO. These additional providers resulted from the inclusion of the Stanford University Clinic in the PPO. Appendix

H shows the comparison of the number of providers in Santa Clara County in the CSJEHP to Santa Clara County's Preferred 100 Plan as of January 7, 1994.

There are 4,283 physicians in Santa Clara County according to the Medical Board of California. The City's PPO has 949, or 22.1 percent, of the total physicians in Santa Clara County. Santa Clara County's Preferred 100 Plan has 2,263 physicians in its PPO, or 52.8 percent, of the total physicians in Santa Clara County. According to Santa Clara County's Cost Containment personnel, the Preferred 100 Plan has approximately 5,300 physicians and 1,700 other providers such as psychologists, marriage and family counselors, social workers, podiatrists, and chiropractors.

The City Can Benefit From Forming
A Health Care Coalition With Santa Clara County

The president of the Health Research Institute in Walnut Creek provided us with information demonstrating the success of Santa Clara County's labor-management health care committee. In 1991, the State and Local Government Labor-Management Committee in Washington, D.C., made the following comments about Santa Clara County's labor-management health care committee:

> *Since 1983, the Santa Clara County Labor Management Health Committee has implemented a series of innovative programs to contain health care costs in its self-insured indemnity plan. Recent initiatives include an aggressive claims auditing program that reviews all claims to identify inaccurate or inflated charges by hospitals and physicians, the development of a preferred provider option, and expanding enrollment in the plan to employees of other local governments, thereby allowing the plan to negotiate more favorable rate reductions with health providers. The plan covers 4,500 active and 2,500 retired employees and their dependents.*
>
> *In 1988, Santa Clara County's labor and management found a way to work together to contain costs and improve benefit coverage, At that time, SEIU Local 715, which represents employees of cities and school districts in Santa Clara County, learned that Blue Cross-Blue Shield planned to cancel their*

group policies. At the same time, Santa Clara County was interested in expanding the number of employees covered by its self-insured plan so it could negotiate even better rates with physicians and hospitals as part of its PPO network. Labor and management, therefore, agreed to open enrollment in the county's self-insured plan to local governments and school districts that entered into an agreement with the county. Within two years, the number of covered employees increased from 800 to 4,500. This expanded employee base helped the county negotiate even greater rate reductions with PPO providers.

Appendix I presents more detailed comments about Santa Clara County's labor-management health care committee.

In an article entitled "Trimming Health Benefit Costs" in the August 1994 American City and County magazine, Albert Jones said,

Increasingly, local governments are pooling together for economies of scale and greater negotiating leverage with insurers and providers. Others are joining coalitions of public employers, labor and private sector employers to negotiate with providers and to develop data initiatives to collect and study the appropriateness and quality of the health care their benefit plans finance.

Health care coalitions have been used in Florida, Michigan, Washington, Minnesota, Tennessee, Ohio, Colorado, Iowa, Massachusetts, and Illinois. In an article in the September 1993 Personnel Journal, the following comments were made: "*Human Resources executives are banding together in communities throughout the U.S. to form health-care coalitions. Through their purchasing power, these coalitions are changing the way that health care is purchased and delivered in this country*."

There are close to a hundred of these employer-driven coalitions, according to the National Business Coalition Forum on Health in Washington, D.C. Health care coalitions are not a new idea. Many of them have been around for more than a decade. They were originally designed for the purpose of exerting raw economic leverage and achieving some significant discounts in the cost of health care. Today,

as the coalition movement spreads, employers are demanding both quality and cost effectiveness from the health care system. More than gaining price reduction, members hope to encourage providers to deliver efficient, high quality health care to the local communities. Employer-led coalitions share a common belief that because health care is a local industry, reform must be community-based.

In continuing with the present PPO and the present TPA, CSJEHP will forego during 1994-95 more than $1 million in reduced expenses that it should realize by forming a purchasing alliance with Santa Clara County's self-insured health care plan.

The CSJEHP lags behind Santa Clara County's self-insured health care plan in certain cost savings features. These cost savings features are:

1. Purchasing alliance with other governmental and quasi-governmental jurisdictions;
2. Larger number of physicians in the PPO in the County;
3. Better physician discount rates;
4. Direct negotiation with hospitals, doctors, and other providers;
5. Expedient payment discounts;
6. Expanded concurrent utilization review; and
7. Greater utilization of PPO hospitals and physician services.

By forming an alliance with Santa Clara County's plan, the CSJEHP will be able to

- Gain purchasing economies of scale and attract medical service providers into its PPO;
- Obtain better physician discount rates;
- Obtain expedient-payment discounts;
- Implement additional concurrent utilization reviews; and
- Increase utilization of PPO physicians and hospitals.

In addition, the administrative costs for the CSJEHP would be about 4 percent less with more services provided for those administrative costs. The consultant for Santa Clara County's Preferred 100 Plan said the County's administration costs would compare to the current CSJEHP administration costs as follows:

	Administration Cost Per Enrollee Per Month	
	Current CSJEHP Cost	**Proposed Cost After Consolidation with Santa Clara County**
Claims Administration	$9.23	$10.10
Pre-admission	1.85	2.00*
Concurrent Utilization Review	N/A	*
Large Case Management	**	*
PPO	1.50	*
Totals	$12.58	$12.10

* $2.00 included charges for pre-admission, concurrent utilization review, large case management, and PPO.

** Under the current CSJEHP, the City pays $195 per hour for large case management services which is in addition to the $12.58 per enrollee per month.

In addition, Santa Clara County's plan would have additional annual costs of about $10,000 for brochures, claims forms, and enrollment cards. The CSJEHP costs about 4 percent more with its current rate of $12.58 per enrollee per month. Appendix J presents excerpts of the contract between Santa Clara County and its TPA describing claims administration services offered for Santa Clara County's Preferred 100 Plan.

If The City Forms A Coalition With Santa Clara County,
The City Can Obtain Better Price Discounts For Medical Services

Santa Clara County's Preferred 100 Plan has better physician reimbursement rates than the CSJEHP as shown in Table VI.

TABLE VI

RATES COMPARISON
BETWEEN SANTA CLARA COUNTY'S
PREFERRED 100 PLAN AND THE CSJEHP

Category	Preferred 100 Plan Rates	CSJEHP Rates	Percentage Differences
Medicine	$7.00	$7.24	3.43
Surgery	$171.50	$182.58	6.46
Radiology	$13.65	$14.92	9.30
Pathology	$1.63	$1.71	4.91
Anesthesia Bill Charges	90% of UCR	$38.39 - $42.66	*

* The CSJEHP rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

The CSJEHP could have saved approximately $239,000 for the calendar years ending 1991, 1992, and 1993, or about $80,000 per year, if it had the benefit of Santa Clara County's physician reimbursement rates.

Table VII below demonstrates these savings.

TABLE VII

COMPARISON OF CSJEHP PAYMENTS TO SANTA CLARA COUNTY'S RATES FROM 1991 THROUGH 1993

Physician Services (CPT)	CSJEHP Paid	Payment With Santa Clara County's Rate	Savings Lost
Medicine	$2,068,971	$1,998,005	$ 70,966
Surgery	1,881,293	1,759,761	121,532
Radiology	374,440	339,617	34,823
Pathology/ Lab	236,709	225,087	11,622
Anesthesia	122,729	*	*
Uncoded	95,807	**	**
Totals	$4,779,949	N/A	$238,943

* The CSJEHP rates for anesthesia and the County's rates for anesthesia cannot be compared because the County pays these charges at 90 percent of UCR fees.

** Uncoded charges cannot be compared because it is not possible to know what these charges are and how much savings could be realized.

If The City Forms A Coalition With Santa Clara County, The City Can Obtain Fast Payment Discounts

Santa Clara County has expedient-payment discount agreements with PPO hospitals. If PPO hospitals are paid within 20 days for hospital inpatient charges, the County receives discounts ranging from 2 percent to 5 percent. If the CSJEHP had similar agreements, the savings conservatively could have been about $29,000 per year on average as is shown in Table VIII.

TABLE VIII

ESTIMATED DISCOUNTS THE CSJEHP COULD HAVE REALIZED BY USING SANTA CLARA COUNTY'S EXPEDIENT-PAYMENT DISCOUNT AGREEMENT WITH PPO HOSPITALS DURING 1991, 1992, AND 1993

Year	PPO Services Available For Discount	Discount	Total Savings
1991	$1,235,107	2%	$24,702
1992	1,401,407	2%	28,028
1993	1,683,857	2%	33,677
Total	4,320,371	2%	$86,407
Three-Year Average			$28,802

If The City Forms A Coalition With Santa Clara County, The City Can Implement Additional Concurrent Utilization Reviews Of Medical Service Bills

William G. Williams, in the book entitled The Handbook of Employee Benefits, stated the following about utilization review:

> *Hospital utilization review (UR) is designed to reduce the incidence of unnecessary or inappropriate hospitalization. This procedure, used for both cost and quality control, involves the use of locally determined criteria to establish guidelines for appropriate admissions, hospital lengths of stay, and course of treatment. These criteria are based on age, sex, and diagnosis. . . .*
>
> *Hospital utilization can be reviewed on a prospective, concurrent, or retrospective basis. A combination of these approaches comprises the most effective UR program, but concurrent review is the most prevalent.*
>
> ***Prospective Review**. A prospective review program involves preadmission screening by physicians, to limit hospital admissions to those "medically necessary;" . . . Physicians in HMOs often use prospective URs to control hospital utilization.*

While prospective review provides an effective front-line defense against unnecessary hospitalization, its usefulness is limited because control is lost once a patient is admitted and the physician is then free to order any number of tests and keep the patient hospitalized as long as he or she would like. When coupled with concurrent and retrospective review, prospective review can be effective.

***Concurrent Review**. A concurrent review program involves determining whether treatment and continued inpatient care during a patient's hospitalization are necessary and appropriate. Because it can lead to a shortened length of stay, this procedure has definite potential to produce cost-savings.*

***Retrospective Review**. A retrospective review program determines the appropriateness of the care that has been provided and the extent to which hospitalization costs should be reimbursed. This mechanism can create substantial economic incentive for changing patterns of care.*

Thus, utilization review is conducted to determine the following:

1. Unnecessary medical services
2. High cost per unit of service
    a. Billing abuses
    b. Use of high-priced providers
3. Inappropriate settings for services
4. Avoidable illness

FHPA stated it uses a registered nurse to provide telephonic concurrent reviews. This review consists of monitoring a patient's hospital stay on a daily basis in conjunction with the hospital's utilization review department and working with the hospital and attending physician to assure that the patient is discharged within the normative parameters for length of stay that FHPA assigned at the time of admission. According to FHPA, the value of this service is evidenced by the low inpatient days per thousand that the CSJEHP experienced over the term of its contract with FHPA.

FHPA stated in a May 3, 1994, memorandum that it does not audit large hospital bills as a standard service for its clients. FHPA stated it will contract with a hospital review firm at the request of the City; however, charges for such services will be passed along to the CSJEHP.

Santa Clara County employs two registered nurses in the Cost Containment Department to do the following utilization review services for the Preferred 100 Plan:

- Prospective utilization reviews;
- On-site concurrent utilization reviews from San Francisco to Monterey;
- Large case management;
- Claims reviews for all hospital bills;
- Negotiation of one-time-only contracts: e.g., the Cost Containment Department will prospectively negotiate discounts for large bills from non-PPO hospitals; and
- Reviews of medical records.

The registered nurses also consult with physicians as needed.

According to documents Santa Clara County's Cost Containment Department provided to us, the Department's utilization reviews saved the County $12,633 per month, or $151,596 annually, in 1992-93, and $19,019 per month, or $228,228 annually, in 1993-94. Thus, Santa Clara County's utilization reviews saved an average of $189,912 per year in 1992-93 and 1993-94.

Because the City's total enrollment in the CSJEHP of 2,386 is about one half of the 5,000 members in Santa Clara County's Preferred 100 Plan, we estimate the CSJEHP could expect savings of approximately $95,000 per year should the City consolidate its plan with Santa Clara County's.

If The City Forms A Coalition With Santa Clara County,
The City Can Improve Employee Use Of The PPO

We reviewed the CSJEHP's Plan Service Analysis reports for calendar years 1991, 1992, and 1993. These reports summarize the CSJEHP payments made for physician services, hospital and facility charges for inpatient and outpatient services, outpatient pharmacy costs, and dental services. In addition, these reports summarize whether these payments were made to physicians, hospitals, or pharmacists who are in the PPO as well as those outside the PPO. Thus, these reports can be used to determine the extent to which the participants are taking advantage of the discounts negotiated by PPO Alliance with the physicians and hospitals.

The extent to which CSJEHP participants use PPO providers versus non-PPO providers is significant. According to HRD personnel, the overall average percentage discount realized by CSJEHP participants using a PPO provider is 25 percent. Thus, when CSJEHP participants use a non-PPO provider, a potential 25 percent discount is lost. Table IX shows the CSJEHP non-PPO costs for 1991, 1992, and 1993 and our estimate of the savings that the City's employees and retirees would have achieved had these services been provided within the PPO. Particularly noteworthy is that the physician services outside the PPO for 1991, 1992, and 1993 were about 56 percent.

It should be noted that these savings are predicated on the basis that negotiated rates are 25 percent less than non-PPO rates and these negotiated rates can be applied to all PPO provider services.

TABLE IX

CSJEHP NON-PPO COSTS AND ESTIMATED RESULTANT SAVINGS LOST DURING 1991, 1992, AND 1993

	1991, 1992, And 1993			
Services	**Total CSJEHP Costs**	**CSJEHP Non-PPO Costs**	**Percentage Of CSJEHP Non-PPO Costs**	**Estimated Savings Lost Due To CSJEHP Use Of Non-PPO Providers**
Physician	$10,824,427	$6,044,469	55.8	$1,511,117
Hospital	13,251,539	6,125,875	46.2	1,531,469
Outpatient Pharmacy	3,013,387	1,819,607	60.4	454,902
Dental Services	42,347	25,405	60.0	N/A
Average	$9,043,900	$4,671,785		$1,165,829

As shown in Table IX, we estimate that the City's employees and retirees would have saved approximately $1,165,829 annually had CSJEHP members used PPO physicians and hospital services instead of going outside the PPO.

Utilization Of The PPO: CSJEHP Compared To Santa Clara County's Preferred 100 Plan

To evaluate the effectiveness of the City's use of discounted PPO provider services, we compared the 1992-93 usage of PPO physicians for both Santa Clara County's Preferred 100 Plan and the CSJEHP. We used the percentage of payments for the medicine and surgery categories as the basis for our comparison because these services comprise about 82 percent of paid physician services. Table X shows this comparison.

TABLE X

COMPARISON OF THE 1992-93 USAGE OF PPO PHYSICIANS FOR SANTA CLARA COUNTY'S PREFERRED 100 PLAN TO THE CSJEHP FOR MEDICINE AND SURGERY CATEGORIES

Category	Preferred 100 Plan Dollars Paid For PPO Services	CSJEHP Dollars Paid For PPO Services	Difference In PPO Utilization
Medicine	79%	44%	35%
Surgery	72%	58%	14%

We calculated the effect of the CSJEHP achieving results similar to what Santa Clara County's Preferred 100 Plan achieved for usage of PPO providers for medicine and surgery. We estimate that the CSJEHP could annually save about $196,000 per year, assuming the difference in PPO utilization shown above and an average PPO provider discount rate of 25 percent. Our estimate of $195,885 in annual savings due to the CSJEHP's PPO utilization replicating Santa Clara County's Preferred 100 Plan is shown in Table XI.

TABLE XI

ESTIMATED SAVINGS DUE TO THE CSJEHP'S PPO UTILIZATION REPLICATING SANTA CLARA COUNTY'S PREFERRED 100 PLAN

	A	B	C	D
CSJEHP Physician Services	Total CSJEHP Services For 1993	Difference In PPO Utilization	Estimated PPO Savings	Annual Savings (A x B) C
Medicine	$1,777,092	35%	25%	$155,496
Surgery	1,153,972	14%	25%	40,389
Totals	***$2,931,064***	***N/A***	***25%***	***$195,885***

Appendix K shows the detail of Santa Clara County's Preferred 100 Plan members using PPO providers for physician and surgery services for a two-year period.[9]

Usage Of PPO Hospitals

The CSJEHP's costs for PPO hospitals versus non-PPO hospitals as percentages of the total for 1991, 1992, and 1993 were:

Year	PPO Percentage
1991	50
1992	49
1993	60

It should be noted that Santa Clara County's PPO hospital costs in 1993 were 76.15 percent compared to the City's 60 percent. If the CSJEHP were to achieve the same 76.15 percent of hospital charges in its PPO, the annual savings would be $192,276 as follows:

[9] It should also be noted that Preferred 100 Plan participants' utilization of its PPO is somewhat attributable to the following incentives in the Plan:

a. After the Plan has paid $14,000 in benefits for covered charges from a nonparticipating provider for a member in a year, the Plan pays 100 percent of UCR-covered expenses incurred by that member for the remainder of that calendar year. Excluded from Plan stop-loss provisions are outpatient services under Mental or Nervous Disorders, Substance Abuse and Designated Procedures in the Preferred Provider Service Area Incentive Program and items paid under Prescription Plan benefits.

b. The Preferred 100 Plan has 32 procedures for which the Plan pays 100 percent if the member elects to have the procedure done in a participating facility. However, if the member elects to have the procedure done at a nonparticipating facility and there is a participating facility within 50 miles of where the member had the procedure done, the Plan payment for facility-generated charges will be 50 percent of UCR fees. No stop-loss applies to these procedures.

Total hospital charges for calendar year ending 1993 .....$4,762,256.00

Times 16.15 percent (76.15 minus 60.0) $769,104

$769,104.34 times 25 percent (PPO-stated discount) $192,276

If The City Forms A Coalition With Santa Clara County,
The City's Employees And Retirees Can Save More Than $1 Million Per Year
In Medical Service Costs And Health Insurance Premiums

The CSJEHP can save more than $1 million per year by

- Obtaining better PPO physician reimbursement rates;
- Increasing the size of the PPO in Santa Clara County to maximize potential savings and meet its employees' needs;
- Improving the usage by participants of the PPO;
- Implementing additional concurrent utilization reviews;
- Ensuring that the TPA applies the negotiated rates to all physician services; and
- Establishing a cooperative purchasing agreement with the County, resulting in better prices.

Table XII is a summary of the total savings.

TABLE XII

SUMMARY OF TOTAL SAVINGS TO EMPLOYEES AND RETIREES IF THE CSJEHP HAD THE SAME BENEFITS AS SANTA CLARA COUNTY'S PREFERRED 100 PLAN

If City Had The Benefits Of Santa Clara County's Plan	1991 Savings	1992 Savings	1993 Savings	Total Savings	Yearly Average	Average Savings
Savings if the County's physician service rates were in effect	$66,001	$ 85,407	$ 87,535	$ 238,943	$ 79,648	$ 79,648
Savings if the County's expedient-payment discounts were in effect	24,702	28,028	33,677	86,407	28,802	28,802
Savings if the County's utilization reviews were in effect		$151,596	228,228	379,824	189,912	94,956*
Savings if City achieved the County's percentage of PPO utilization for physician services for medicine			155,496	155,496	155,496	155,496
Savings if City achieved the County's percentage of PPO utilization for physician services for surgery			40,389	40,389	40,389	40,389
Savings if City achieved the County's percentage of PPO utilization for hospitals			192,276	192,276	192,276	192,276
Total savings if with County	$90,703	$265,031	$737,601	$1,093,335	$686,523	$591,567
Opportunities/savings to be gained as a result of having relative values for CPT codes.**						231,864
Savings from economies of scale and mitigating future cost increases***						$198,954
Grand Total						$1,022,385****

* Because the CSJEHP's enrollment is approximately 50 percent of the enrollment in Santa Clara County's Preferred 100 Plan, we estimated the City's savings from concurrent utilization review to be 50 percent of $189,912.

** This amount was computed by multiplying the estimated monthly discount lost of $19,322, as discussed on page 35, by 12 to annualize the amount of savings.

*** Estimate of 2 percent provided by the consultant for Santa Clara County's Preferred 100 Plan and confirmed by the president of Health Research Institute in Walnut Creek. We used the average of the CSJEHP payment of claims amounts for the last three years to quantify the estimate.

**** This total amount is actually understated because we have not included an estimate for savings related to subrogation. Subrogation involves recovering payments which were the responsibility of a third party. Savings from subrogation depends on the number of cases identified and pursued. FHPA does not include subrogation work in its claims administration. In contrast, the County's claims administration cost includes such work. Santa Clara County's Preferred 100 Plan estimated savings of about $90,000 in 1994 and $48,000 for the first two months of 1995. While we do not make a separate savings estimate for subrogation, the City's benefits administrator estimated subrogation savings of at least $180,000 in 1990.

Santa Clara County Has Expressed Interest
In A Coalition With The City

During a meeting between Santa Clara County representatives and the City Auditor's Office in June 1994, the County representatives expressed an interest in forming a coalition between Santa Clara County and the city of San Jose. The City is planning to conduct an RFP selection process for the claims administrator and the PPO for the CSJEHP. In our opinion, the City should invite and encourage Santa Clara County to participate in the City's RFP process.

CONCLUSION

The city of San Jose (City) offers its employees three health care plans of which one is the City of San Jose Employees' Health Plan (CSJEHP). The City contracts with PPO Alliance to administer a series of contractual arrangements with a network of physicians, hospitals, and other medical service providers. The medical service providers with which PPO Alliance contracts are the City's preferred provider organization (PPO). As such, it is in the best interest of the City and its employees that PPO Alliance contract with as many medical service providers as possible and that it negotiate the best possible price for specific medical procedures. In addition, the City contracts with a third-party administrator--Foundation Health Preferred Administrators (FHPA)--to pay and administer claims for services to employees in the CSJEHP that medical service providers submit for payment. As such, it is in the best interest of the City and its employees that the FHPA pay claims in a timely manner and take advantage of all negotiated or available medical service discounts.

Our review of the City's contractual arrangement with PPO Alliance and FHPA and their performance under the City's contract revealed the following:

- At the recommendation of the Benefits Review Forum, the City awarded a contract to PPO Alliance without going through a competitive bidding process;
- PPO Alliance has not provided the City or its employees with a number of medical service providers in its PPO comparable to Santa Clara County's;
- PPO Alliance has not negotiated discount rates with medical service providers in its PPO comparable to Santa Clara County's;
- FHPA has not paid medical service claims in a timely manner;
- FHPA has not taken advantage of negotiated or available medical service discounts and as a result cost the City's employees and retirees $890,000 over the last four years; and
- FHPA paid about $15,000 for ineligible claims during the last four years.

Santa Clara County has a PPO option for its employees known as the Preferred 100 Plan. Our review revealed that by consolidating with the County for a PPO, the City and its employees will be able to

- Obtain better price discounts for medical services;
- Obtain fast-payment discounts;
- Implement additional concurrent utilization reviews of medical service bills; and
- Increase employee use of the PPO.

By forming a medical services purchasing alliance with Santa Clara County, we estimate that City employees will save more than $1 million a year in medical service costs and health insurance premiums. In addition, the City should pursue reimbursement of $905,000 in prior years' overpayments.

RECOMMENDATIONS

We recommend that the Human Resources Department:

Recommendation #1:

Require PPO Alliance and Foundation Health Preferred Administrators to provide relative unit values for all applicable medical services and procedures. (Priority 1)

Recommendation #2:

Require Foundation Health Preferred Administrators immediately to apply the already-negotiated and available discounts described in the PPO Alliance's Physician Reimbursement Schedule. (Priority 1)

Recommendation #3:

Set a deadline for Foundation Health Preferred Administrators (FHPA) to provide the documentation that was requested during the audit. If FHPA fails to provide the documentation, disallow the amounts paid for undocumented medical claims. (Priority 1)

Recommendation #4:

Require Foundation Health Preferred Administrators to provide the City with a payment report from August 1, 1990, to April 30, 1992, and a separate report from May 1, 1992, to the present for all PPO procedures which were paid as billed because there were no relative values to compute a discount. Each report should show (1) the claim number, (2) date of service, (3) the procedure code

number and description, (4) the billed and paid amount, and (5) billed and paid totals for the two report periods. After determining the dollar value of 10 percent and 20 percent discounts not taken, request the City Attorney to initiate actions to recover any overpayments. (Priority 1)

Recommendation #5:

Develop and implement procedures to ensure that the current eligibility files for the City of San Jose Employees' Health Plan are complete and accurate. (Priority 3)

Recommendation #6:

Develop and implement procedures to monitor the continuing eligibility of the employees and their dependents for the City of San Jose Employees' Health Plan. Such procedures could include requesting the third-party administrator to periodically produce an exception report of potential ineligible dependents as a basis for monitoring eligibility. (Priority 3)

Recommendation #7:

Consult with the City Attorney regarding possible City recourse to recover amounts paid on ineligible dependent claims between August 1, 1990, and February 28, 1994. (Priority 3)

In addition, we recommend that the Human Resources Department and Benefits Review Forum:

Recommendation #8:

Request funding for a full-time analyst to monitor the City of San Jose Employees' Health Plan. (Priority 2)

Finally, we recommend that the Human Resources Department:

Recommendation #9:

Solicit a proposal from Santa Clara County in the next scheduled City of San Jose Employees' Health Plan request for proposal process for the selection of the claims administrator and the preferred provider organization. (Priority 1)

Recommendation Requiring Budget Action

Of the preceding recommendations, #8 may not be able to be implemented absent additional funding. Accordingly, the City Manager should request during the 1995-96 budget process that the City Council appropriate an amount sufficient to implement recommendation #8.